Research Article

Global Health in the 21st Century: The Need for a Strategic Funding Plan

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Abstract

Global health has been frequently described in literature as a "fashionable" and "hot" topic; the rise in the amount of philanthropic donors, international organizations, Non-Government Organizations (NGO's) and countries which identify it as a top priority clearly explain this trend. This has resulted in the proliferation of global health programs and initiatives aimed at addressing the endemic health challenges faced in low and middle income countries. This in turn has resulted in the rise of several fragmented interventions programs that do not contribute to the overall capacity building of the health systems in these countries. Sadly, this represents a wasted opportunity, as these funds could be channeled into the sustained, long term capacity development of these health systems. To address the unique challenges faced globally, more needs to be done by both donors and the government of the countries to ensure that the funds are appropriately utilised and I shall discuss a course of action throughout this paper. This ensures that countries are appropriately empowered to address the dynamic and evolving health threats faced, and that the World Health Organization (WHO) 'health for all' call is attained.

Keywords: Global Health, World Health Organization, Funding, Strategic Funding

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Introduction

The World Health Organization (WHO), Alma Ata conference held in 1978 was the basis on which the primary health care movement was established. At this conference, representatives from countries across the globe adopted the "health for all" movement, with the sole aim of improving health care coverage around the world, especially in deprived settings (Rasanathan et al., 2009; Basilico et al., 2013). Thirty eight years have passed since the Alma Ata conference, and despite huge change in global health actors that has seen an unprecedented rise in aid funds to low income countries (Weigel et al., 2013), most of the countries involved still fall short of achieving the "health for all" mark. Whilst some of these countries have experienced improvement in health, most face a battle with the same endemic diseases that billions have been channelled towards eradicating.The acceleration of globalization activities, spurred on by increased technology and economic interdependence, has created easy movement of goods, services and people globally (Ollila, 2005). However, the threat posed by pathogens and infectious diseases saliently emphasizes how the inadequacies experienced by health systems in some countries could further exacerbate the risks posed due to the aforementioned developments (Ollila, 2005).

In this paper, I will argue that despite the influx of huge aid donations to health, the lack of quality and functional health systems in low/ middle income countries (LMICs) remains one of the biggest global health challenges. Firstly, I shall explain the challenges within these countries and globally due to the inadequate health systems, and then suggest a strategy to mitigate them.

Aid and Health Systems in LMICs

To put this situation into context, I will start by providing some background information. In 1978, representatives from different countries gathered at Alma Ata for a conference that adopted the call for a health system that was community based, encompassing a broad range of features to address the varied health challenges faced by individual countries (Rasanathan et al., 2009; Basilico et al., 2013). This vision was termed "primary health care", and its emphasis was upon universal health coverage for all by the year 2000 (Basilico et al., 2013). However, the lack of clear implementation goals and the rise of neoliberalism in the 1980s saw this vision fall through (Basilico et al., 2013). The onset of neoliberalism was marked by depleted funding to health care systems in some LMICs

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to correspond with structural adjustment loans by the World Bank and the International Monetary Fund (IMF) (Basilico et al., 2013). This resulted in even weaker and debilitating health systems in these LMICs.

In the past twenty years, health aid to low and middle income countries has increased precipitously; from the years 1990 to 2007, aid assistance to LMICs rose from 5.59 to 21.79 billion dollars (Weigel et al., 2013). This rise in aid donation to health was incited by the emergence of new global health actors such as the Gates foundation, multilateral agencies like the Presidents Emergency Fund for AIDS Relief (PEPFAR), Global Alliance for Vaccines and Immunizations (GAVI), the Global Fund, and bilateral aid from OECD countries (Doyle and Patel, 2008; Sridhar and Batniji, 2008). Despite the unprecedented rise in aid funding to LMICs, health care in these countries still falls below the global standards, poor nutrition and sanitation remain, and the huge health divide between countries is still evident (Weigel et al., 2013).

The rise in funding from aid donors has seen several high profiled endemic diseases facing LMICs (HIV, tuberculosis, malaria, child and maternal health) become prioritized (Ollila, 2005). It is important to note that most of these funds are channelled into specific Non-Governmental Organizations (NGOs) working within these countries and do not go into health systems (Sridhar and Batniji, 2008). This has largely resulted in various uncoordinated disease specific efforts by these NGOs and has not brought about structural changes to the health systems of these LMICs (Pfeiffer, 2003; Ollila, 2005). In addition, Marchal et al. (2009) found that although most global actors claimed to support health systems in the countries in which they operated, their funds were directed towards vertical (disease specific) programs that did not positively impact upon health systems. Furthermore, some studies have argued that the increased funding might have brought about an erosion of these health systems rather than strengthening them (Pfeiffer, 2003; Swanson et al., 2009). This results in even weaker systems that are unable to meet the needs of their population (Marchal et al., 2009).

The lack of quality health care in these countries poses a grave challenge to global public health. Firstly, these health systems are not able to address the growing health needs of their population and the gap in access is left to NGOs to tackle. However, the selective prioritization of NGOs means

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that they cannot always address the health needs of the people (Ollila 2005). In addition, the growing double burden of diseases experienced by LMICs, in which communicable diseases still impact on health systems and non-communicable diseases exert enormous burden, drastically compounds the burden to these already compromised health systems (Ollila, 2005). This may further widen the health disparities between rich and poor countries, and increase the level of poverty in the LMICs (Marchal et al., 2009). This adequately emphasizes the need for quality health systems that uphold the ideals of Alma Ata, by adapting to local context in order to address its unique health demands (Basilico et al., 2013).

The inability of health systems in LMICs to address its health demands not only affects those individual countries, but could possibly create a ripple effect globally. The increased ease of movement globally, especially within the last few decades, poses the peril of endemic communicable disease being spread with relative ease. The rise of new infectious diseases and the possible mutations of the old endemic pathogens require systems strong enough to combat the source, thus preventing the possible global spread of such pathogens (Khan and Lurie, 2014). Pathogens that cause infectious diseases do not respect borders, and the free and easy movement of people brought about by an increased global interconnectedness underscores the need for vibrant health systems, strong enough to address the unique health challenges posed by infectious diseases (Ollila, 2005; Khan and Lurie, 2014). The 2009 H1N1 pandemic and the recent Ebola crisis, which began in Guinea before spreading to other countries within the region with sporadic cases arising across the globe, highlight the global threat posed by the health system's inability to meet the health demands of its people.

One of the major cross cutting challenges facing global health today is meeting the potential health demands and threats posed by a myriad of health conditions; although there are other existing health challenges, most of the problems emanate from how and what is needed in order to address the threats faced by health systems in LMICs that are incapable of meeting their health demands. Most global health actors support the idea of strengthening health systems as a sustainable, long term approach to addressing this threat (Pfeiffer, 2003; Marchal et al., 2009). However, most of the health systems in LMICs are weak and underfunded, and the huge aid funds sent to these countries are channelled into fragmented intervention programs (Ollila, 2005; Marchal et al., 2009). Thus,

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the inability of health systems in LMICs to combat the health needs of the people remains the fundamental backbone to the global health challenge, with further challenges stemming from the need to address this core issue. As such, I consider the lack of quality health systems that meet the demands of the people in LMICs to be one of the biggest challenges to global health.

Strategies to Combat the Challenge

There are several possible strategies that would address this challenge, but my approach would be centred upon an evidence based strategy that has been tested in limited settings with positive results. There has been a renewed emphasis on the Alma Ata vision, spearheaded by the director general of WHO, Dr Margaret Chan. However, while the health for all vision may have been a brillaint idea, it lacked a precise funding and implementation plan (Basilico et al., 2013). My strategy would adopt the community based ideology of Alma Ata and fuse it with the accompaniment model, which builds upon the shortcomings of the Alma Ata idea by indicating an implementation plan (Weigel et al., 2013). It ensures that the huge splurge in aid finances sent to these countries is not used to pay for fragmented and unsustainable health services, but instead goes to help build the health systems in these countries, whilst ensuring that the health systems adapt to community needs.

The premise of this fused approach is to patiently support the capacity development of health systems in LMICs through aid funds, until they can deliver quality health care services independently (Weigel et al., 2013). It consists of a stepwise strategy that firstly ensures that the services provided are representative of the needs of the people, and does not just selectively prioritize high profiled diseases. This ensures that the intervention would be community based, conforming to the ideals of Alma Ata. Secondly, global health funders would have to ensure that NGOs are funded on the criteria that the funds would be used to help build and strengthen health systems and create jobs by working with National governments. This approach was adopted by the Red Cross in Haiti after the earthquake in 2010 to help the hospital with a salary support system (Weigel et al., 2013). This was no easy feat as it involved infrastructural changes to the system in order to upkeep transparency; however, the Red Cross were patient enough to follow this process through. Other examples of this approach adapted within different settings have produced

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favourable results. Finally, governments within these countries would be required to detail the activities of NGOs in their countries, irrespective of who is funding the program (Swanson et al., 2009). This would ensure accountability by NGOs through adequate monitoring and evaluation on the part of the countries.

The approach detailed here is not a blueprint of an ideal strategy; it simply merges two pragmatic approaches in order to adjust for the inadequacies in both. Adopting this model would by no means solve the challenge instantaneously, however, it would ensure that health systems in LMICs could better adapt and would create long term sustainable solutions to address their plethora of health needs.

Conclusion

In the past two decades, global health has evolved into a target for philanthropic donors, yet the old challenges still persist. Access to sound and practical health care remains a problem in many LMICs. This poses novel threats to global health as the global networks enforced through globalization highlight the risk posed by inadequate health systems. There is an urgent need to develop the health capacity of these countries in order to sustainably combat major health threats. Such developments would ensure that health access is equitable and fair, that global health security is strengthened, and that lives would be improved.

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